Sarah Lawrence College Health & Wellness Center
DOCUMENTATION OF PREVIOUS ADHD TREATMENT

This form must be completed by your current treating provider for review prior to setting up care at Sarah Lawrence College Health and Wellness Center-Counseling and Psychological services for ADHD medication management. SLC Health and Wellness services adheres to best practices with regard to treatment of ADHD through medication management.

Please note that SLC Health and Wellness does NOT refill stimulant medications prior to the completion of our assessment process.

In addition to this form please include a copy of chart notes, information regarding recent prescriptions, and neuropsychological testing if previously completed.

Please email, fax or mail the completed form and accompanying notes back to our office. healthservices@sarahlawrence.edu or Fax: 914-395-2640 or Mail to: 1 Mead Way, Bronxville, NY 10708

Students Name: _____ Date of Birth _____

Providers Name: _____

Specialty: _____

Have you ever diagnosed and treated this patient with ADHD in the past? Yes _____ No _____

If yes, what are the approximate dates you have treated this patient for ADHD? _____

Date of last visit? _____

If No-please have the student contact the Health and Wellness Center. SLC Health and Wellness requires a thorough evaluation for ADHD and further referrals may be required.

Which type? ____Predominate inattention ____combined type ____Predominate hyperactivity

How would you describe your practice? ____ Pediatrician ____Family Practice ____Psychiatry ____Psychologist Other_____

How was this diagnosis made? (Check all that apply)

____ Neuropsychological testing
____ Clinical Interview and observation over time
____ Validated checklists by patient
____ Validated checklists via parents and/or teachers
____ Referral to Psychiatrist
____ Referral to Psychologists
____ Other _____

Please list any medication this patient is currently taking:

_____

_____

_____

_____

_____

_____

Please state if this patient was diagnosed with or treated for any other behavioral health condition: *Please note that when co-occurring issues are present SLC Counseling and Psychological services requires engagement in therapy as part of working with short-term psychiatrist*.

_____

_____

_____

_____

_____

Please list any other medical conditions for this patient:

_____

_____

_____

_____

_____

Do you have any concerns about this patient misusing stimulants or other substances? ____NO _____YES

If yes, please explain:

_____

_____

_____

_____

_____

Name of Provider:_____

Name of Practice: _____

Address: _____

Telephone: _____ Fax:_____

Signature_____

Date_____

Please Note:

*****This form MUST accompany copy of notes and prescription history to be considered for short-term medication management on campus. Additionally neuropsychological testing should be submitted if completed. When neuropsychological testing is not available significant documentation and history must be provided to support diagnosis*****